Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Phyllis Joan Frostenson

Respondent Name
Wausau Business Insurance Co

MFDR Tracking Number
M4-14-0984-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since the carrier, Liberty Mutual, had indicated the requirement for preauthorization, our office submitted a request for preauthorization on 11/2/2012."

Amount in Dispute: $3,544.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charges for services of 11/26/12 have been reviewed and remain denied. Preauthorization was required and requested but with an adverse determination. A copy of the pre-authorization denial letter is attached which included instructions regarding the appeal process."

Response Submitted by: Liberty Mutual,

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2012	72141, 73221	$3,544.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out procedures for preauthorization, concurrent utilization review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X388– Pre-authorization was requested but denied for this service per DWC Rule 134.600
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support requirements of division rules were met?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as X388– Pre-authorization was requested but denied for this service per DWC Rule 134.600." 28 Texas Labor Code §134.600 (8) states, "Preauthorization: a form of prospective utilization review by a payor or a payor's utilization review agent of health care services proposed to be provided to an injured employee." Review of the submitted documentation finds pre-authorization was requested for the disputed services but denied. Therefore, the carrier's denial is supported.
2. 28 Texas Administrative Code §134.600 (p) "Non-emergency health care requiring preauthorization includes:(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline;" As the requestor did not have required authorization to provide the service in dispute, no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.